GARRETSON SCHOOL DISTRICT HEALTH SERVICES

Garretson School District #49-4
505 2nd Street
Garretson, SD 57030
Phone: (605)594-3451
Fax: (605) 594-3443

MEDICATION AND TREATMENT AUTHORIZATION FORM

If this student must take medication during school hours and it cannot be given at home, this form is required. Garretson School District requires this form be completed by the parent for over-the-counter medication and both parent and physician for prescription drugs before administering any medication. Medication must be delivered directly to the health office by the parent/guardian in the original pharmacy container. For the safety of all students, medications are not allowed to be carried/self-administered at school with the exception of epinephrine and emergency inhaler.
***Renewal of this form is required at the start of each school year. ***

Student Name: _____

DOB:_____ Grade: _____

Diagnosis: _____

Name of Medication/Treatment: _____

Dosage/Amount Prescribed: _____

Route (by mouth, eye drops, intranasal, etc.): _____

Time to be Given: _____ Frequency (as needed, daily, weekly): _____

Duration (start date and discontinue date): _____

Possible Side Effects: _____

If this is an emergency medication, Epi-Pen, inhaler, etc., is student permitted to self-administer? Yes _____ No_____

PRESCRIPTION ONLY:

Physician's Printed Name: _____ Date: _____

Physician's Signature: _____ Phone /Fax: _____

_____*The undersigned parent or guardian hereby requests the Garretson School District, through Health Services and /or trained school staff, to administer said child the above described medication and consents to the administration of such medication while on school property or at a school-related event or activity. Parent or guardian is responsible for providing medication directly to school personnel in pharmacy-labeled or original bottle, and is responsible for picking up unused medication. I acknowledge and agree that the school shall secure the medication for the student until administration of the medication is necessary, and that in no circumstances shall the medication be stored in the student's locker.*

_____***Epinephrine Auto-Injectors and Inhalers only:*** *I authorize my child to carry & self-administer his/her prescription medication for asthma and/or anaphylaxis while on school property or at a school-related activity or event.* ***Physician order and statement that student is capable of self -administration required.***

_____*Parent or guardian hereby expressly relieves the Garretson School District, the School Board of the District and all agents of the District from any liability for injury arising from the administration or self-administration of such medication.*
I give my permission for the school nurse to discuss with the above named physician observations of effects on my child relating to the above medication, changes in my child as a result of said medication, and any dosage or time changes in medication scheduling. I authorize the school to inform appropriate school employees who would have a need to know of the administration of medication (i.e. , school nurse, instructors, teacher aides, school administrators, activity supervisors, bus drivers). I authorize the release of any medical or other information necessary to process any Medicaid claims submitted for services received at the Garretson School District. I understand that if the student identified herein uses the medication in a manner other than prescribed, the student may be subject to disciplinary action by the school; however, any disciplinary action may not limit or restrict the student's immediate access to the medication.

_____ _____
Signature of Parent/Guardian *Date*

Reviewed by School Nurse_____ Date_____

TURN OVER-
please fill out the back page!

Annual Health Record Updates

Garretson School District 49-4
505 2nd St. PO Box C
Garretson, SD 57030
Phone (605)594-3451

Student's Name_____

HEALTH CONDITIONS (check those that apply) ☐ None

BOLD items (**Asthma, Allergies, Medical Conditions, Seizures**) require additional forms completed by a physician. Forms can be found on school website under Health, or contact school nurse.

☐ ADD/ADHD
☐ **Allergies**
- **Food**_____
- Seasonal_____
- **Medications**_____
- **Other**_____
- **Require Epi Pen?** ☐**Y** ☐**N**

☐ **Asthma**

☐ Other (please list)_____

☐ Bone/Muscle/Joint Problems
☐ Bowel/Bladder Problems
☐ **Cardiovascular (Heart/Blood Pressure)**
☐ Celiac Disease
☐ **Diabetes**
☐ Headaches/Migraines
☐ Head Injury Date_____
☐ Hearing Impaired Hearing Aid(s) ___Y ___N
☐ **Seizure Disorder**
☐ Visually Impaired Glasses ___Y ___N

Please explain any of the above checked items:

_____

_____

_____

Do any health and/or medical conditions require school restrictions, modifications or intervention?
☐ **Yes** ☐ **No** If Yes, please explain_____

IMMUNIZATIONS:

Pre-K & Kindergarten Requirements

4 or more doses of DTAP

4 or more doses of IPV (polio)

2 doses of MMR

2 doses of Varicella

6th Grade Requirements

1 dose Tdap

1 dose Meningococcal vaccine (MCV4)

☐**Yes** ☐**No** New immunizations were administered in the past 6 months

☐**Yes** ☐**No** Immunizations were administered in the state of South Dakota

- If YES, paper copies NOT required.
- If NO, submit paper copies – this is **REQUIRED!**

☐ **Yes** ☐ **No** If student is entering Pre-K, Kindergarten, 6th grade, or is an out-of-state transfer student, all immunizations are up to date or exemption form signed.

- **If NO, student may not be allowed to start school until completed!**
- Contact school nurse for exemption form and/or immunization requirements

Parent/Guardian Signature_____ Date_____